

MA organizations may establish separate plan rules for these services and benefits, subject to CMS review and approval. CMS may, at its discretion, issue overriding instructions limiting or revising the MA plan rules, depending on the specific NCD or legislative change in benefits. For these services or benefits, the Medicare enrollee will be responsible for MA plan cost sharing, as approved by CMS or unless otherwise instructed by CMS.

[68 FR 50856, Aug. 22, 2003, as amended at 70 FR 4721, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005]

**§ 422.110 Discrimination against beneficiaries prohibited.**

(a) *General prohibition.* Except as provided in paragraph (b) of this section, an MA organization may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an MA plan offered by the organization on the basis of any factor that is related to health status, including, but not limited to the following:

- (1) Medical condition, including mental as well as physical illness.
- (2) Claims experience.
- (3) Receipt of health care.
- (4) Medical history.
- (5) Genetic information.
- (6) Evidence of insurability, including conditions arising out of acts of domestic violence.
- (7) Disability.

(b) *Exception.* An MA organization may not enroll an individual who has been medically determined to have end-stage renal disease. However, an enrollee who develops end-stage renal disease while enrolled in a particular MA organization may not be disenrolled for that reason. An individual who is an enrollee of a particular MA organization, and who resides in the MA plan service area at the time he or she first becomes MA eligible, or, an individual enrolled by an MA organization that allows those who reside outside its MA service area to enroll in an MA plan as set forth at § 422.50(a)(3)(ii), then that individual is considered to be “enrolled” in the MA

organization for purposes of the preceding sentence.

[63 FR 35077, June 26, 1998; 63 FR 52612, Oct. 1, 1998; 64 FR 7980, Feb. 17, 1999, as amended at 65 FR 40321, June 29, 2000; 70 FR 4721, Jan. 28, 2005]

**§ 422.111 Disclosure requirements.**

(a) *Detailed description.* An MA organization must disclose the information specified in paragraph (b) of this section—

- (1) To each enrollee electing an MA plan it offers;
- (2) In clear, accurate, and standardized form; and
- (3) At the time of enrollment and at least annually thereafter, 15 days before the annual coordinated election period.

(b) *Content of plan description.* The description must include the following information:

(1) *Service area.* The MA plan’s service area and any enrollment continuation area.

(2) *Benefits.* The benefits offered under a plan, including applicable conditions and limitations, premiums and cost-sharing (such as copayments, deductibles, and coinsurance) and any other conditions associated with receipt or use of benefits; and to the extent it offers Part D as an MA-PD plan, the information in § 423.128 of this chapter; and for purposes of comparison—

(i) The benefits offered under original Medicare, including the content specified in paragraph (f)(1) of this section;

(ii) For an MA MSA plan, the benefits under other types of MA plans; and

(iii) For a Special Needs Plan for dual-eligible individuals, prior to enrollment, for each prospective enrollee, a comprehensive written statement describing cost sharing protections and benefits that the individual is entitled to under title XVIII and the State Medicaid program under title XIX.

(iv) The availability of the Medicare hospice option and any approved hospices in the service area, including those the MA organization owns, controls, or has a financial interest in.

(3) *Access.* (i) The number, mix, and distribution (addresses) of providers from whom enrollees may reasonably be expected to obtain services; any out-

of network coverage; any point-of-service option, including the supplemental premium for that option; and how the MA organization meets the requirements of §§ 422.112 and 422.114 for access to services offered under the plan.

(ii) The process MA regional plan enrollees should follow to secure in-network cost sharing when covered services are not readily available from contracted network providers.

(4) Out-of-area coverage provided under the plan, including coverage provided to individuals eligible to enroll in the plan under § 422.50(a)(3)(ii).

(5) *Emergency coverage.* Coverage of emergency services, including—

(i) Explanation of what constitutes an emergency, referencing the definitions of emergency services and emergency medical condition at § 422.113;

(ii) The appropriate use of emergency services, stating that prior authorization cannot be required;

(iii) The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent; and

(iv) The locations where emergency care can be obtained and other locations at which contracting physicians and hospitals provide emergency services and post-stabilization care included in the MA plan.

(6) *Supplemental benefits.* Any mandatory or optional supplemental benefits and the premium for those benefits.

(7) *Prior authorization and review rules.* Prior authorization rules and other review requirements that must be met in order to ensure payment for the services. The MA organization must instruct enrollees that, in cases where noncontracting providers submit a bill directly to the enrollee, the enrollee should not pay the bill, but submit it to the MA organization for processing and determination of enrollee liability, if any.

(8) *Grievance and appeals procedures.* All grievance and appeals rights and procedures.

(9) *Quality improvement program.* A description of the quality improvement program required under § 422.152.

(10) Disenrollment rights and responsibilities.

(11) *Catastrophic caps and single deductible.* MA organizations sponsoring

MA regional plans are required to provide enrollees a description of the catastrophic stop-loss coverage and single deductible (if any) applicable under the plan.

(12) *Claims information.* CMS may require an MA organization to furnish directly to enrollees, in the manner specified by CMS and in a form easily understandable to such enrollees, a written explanation of benefits, when benefits are provided under this part.

(c) *Disclosure upon request.* Upon request of an individual eligible to elect an MA plan, an MA organization must provide to the individual the following information:

(1) The information required in paragraph (f) of this section.

(2) The procedures the organization uses to control utilization of services and expenditures.

(3) The number of disputes, and the disposition in the aggregate, in a manner and form described by the Secretary. Such disputes shall be categorized as

(i) Grievances according to § 422.564; and

(ii) Appeals according to § 422.578 et. seq.

(4) A summary description of the method of compensation for physicians.

(5) Financial condition of the MA organization, including the most recently audited information regarding, at least, a description of the financial condition of the MA organization offering the plan.

(d) *Changes in rules.* If an MA organization intends to change its rules for an MA plan, it must:

(1) Submit the changes for CMS review under the procedures of § 422.80.

(2) For changes that take effect on January 1, notify all enrollees at least 15 days before the beginning of the Annual Coordinated Election Period defined in section 1851(e)(3)(B) of the Act.

(3) For all other changes, notify all enrollees at least 30 days before the intended effective date of the changes.

(e) *Changes to provider network.* The MA organization must make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all enrollees

who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care professional, all enrollees who are patients of that primary care professional must be notified.

(f) *Disclosable information*—(1) *Benefits under original Medicare*. (i) Covered services.

(ii) Beneficiary cost-sharing, such as deductibles, coinsurance, and copayment amounts.

(iii) Any beneficiary liability for balance billing.

(2) *Enrollment procedures*. Information and instructions on how to exercise election options under this subpart.

(3) *Rights*. A general description of procedural rights (including grievance and appeals procedures) under original Medicare and the MA program and the right to be protected against discrimination based on factors related to health status in accordance with § 422.110.

(4) *Potential for contract termination*. The fact that an MA organization may terminate or refuse to renew its contract, or reduce the service area included in its contract, and the effect that any of those actions may have on individuals enrolled in that organization's MA plan.

(5) *Benefits*. (i) Covered services beyond those provided under original Medicare.

(ii) Any beneficiary cost-sharing.

(iii) Any maximum limitations on out-of-pocket expenses.

(iv) In the case of an MA MSA plan, the amount of the annual MSA deposit.

(v) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

(vi) The types of providers that participate in the plan's network and the extent to which an enrollee may select among those providers.

(vii) The coverage of emergency and urgently needed services.

(6) *Premiums*. (i) The MA monthly basic beneficiary premiums.

(ii) The MA monthly supplemental beneficiary premium.

(iii) The reduction in Part B premiums, if any.

(7) The plan's service area.

(8) *Quality and performance indicators* for benefits under a plan to the extent they are available as follows (and how they compare with indicators under original Medicare):

(i) Disenrollment rates for Medicare enrollees for the 2 previous years, excluding disenrollment due to death or moving outside the plan's service area, calculated according to CMS guidelines.

(ii) Medicare enrollee satisfaction.

(iii) Health outcomes.

(iv) Plan-level appeal data.

(v) The recent record of plan compliance with the requirements of this part, as determined by the Secretary.

(vi) Other performance indicators.

(9) *Supplemental benefits*. Whether the plan offers mandatory and optional supplemental benefits, including any reductions in cost sharing offered as a mandatory supplemental benefit as permitted under section 1852(a)(3) of the Act (and implementing regulations at § 422.102) and the terms, conditions, and premiums for those benefits.

(10) The names, addresses, and phone numbers of contracted providers from whom the enrollee may obtain in-network coverage in other parts of the service area.

(11) If an MA organization exercises the option in § 422.101(b)(3) or (b)(4) related to an MA plan, then it must make the local coverage determination that applies to members of that plan readily available to providers, including through a web site on the Internet.

(g) CMS may require an MA organization to disclose to its enrollees or potential enrollees, the MA organization's performance and contract compliance deficiencies in a manner specified by CMS.

(h) *Provision of specific information*. Each MA organization must have mechanisms for providing specific information on a timely basis to current and prospective enrollees upon request. These mechanisms must include all of the following:

(1) A toll-free customer service call center that meets all of the following:

(i) Is open during usual business hours.

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(ii) Provides customer telephone service in accordance with standard business practices.

(iii) Provides interpreters for non-English speaking and limited English proficient (LEP) individuals.

(2) An Internet Web site that includes, at a minimum the following:

(i) The information required in paragraph (b) of this section.

(ii) Copies of its evidence of coverage, summary of benefits, and information (names, addresses, phone numbers, and specialty) on the network of contracted providers. Such posting does not relieve the MA organization of its responsibility under § 422.111(a) to provide hard copies to enrollees.

(3) The provision of information in writing, upon request.

(i) *Provision of information required for access to covered services.* MA plans must issue and reissue (as appropriate) member identification cards that enrollees may use to access covered services under the plan. The cards must comply with standards established by CMS.

[63 FR 35077, June 26, 1998, as amended at 64 FR 7980, Feb. 17, 1999; 65 FR 40321, June 29, 2000; 68 FR 50857, Aug. 22, 2003; 70 FR 4722, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005; 73 FR 54220, 54249, Sept. 18, 2008; 75 FR 19805, Apr. 15, 2010; 76 FR 21563, Apr. 15, 2011; 77 FR 22167, Apr. 12, 2012]

### § 422.112 Access to services.

(a) *Rules for coordinated care plans.* An MA organization that offers an MA coordinated care plan may specify the networks of providers from whom enrollees may obtain services if the MA organization ensures that all covered services, including supplemental services contracted for by (or on behalf of) the Medicare enrollee, are available and accessible under the plan. To accomplish this, the MA organization must meet the following requirements:

(1) *Provider network.* (i) Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health

agencies, ambulatory clinics, and other providers.

(ii) *Exception:* MA regional plans, upon CMS pre-approval, can use methods other than written agreements to establish that access requirements are met.

(2) *PCP panel.* Establish a panel of PCPs from which the enrollee may select a PCP. If an MA organization requires its enrollees to obtain a referral in most situations before receiving services from a specialist, the MA organization must either assign a PCP for purposes of making the needed referral or make other arrangements to ensure access to medically necessary specialty care.

(3) *Specialty care.* Provide or arrange for necessary specialty care, and in particular give women enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services provided as basic benefits (as defined in § 422.2). The MA organization arranges for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs.

(4) *Service area expansion.* If seeking a service area expansion for an MA plan, demonstrate that the number and type of providers available to plan enrollees are sufficient to meet projected needs of the population to be served.

(5) *Credentialed providers.* Demonstrate to CMS that its providers in an MA plan are credentialed through the process set forth at § 422.204(a).

(6) *Written standards.* Establish written standards for the following:

(i) Timeliness of access to care and member services that meet or exceed standards established by CMS. Timely access to care and member services within a plan's provider network must be continuously monitored to ensure compliance with these standards, and the MA organization must take corrective action as necessary.

(ii) Policies and procedures (coverage rules, practice guidelines, payment policies, and utilization management) that allow for individual medical necessity determinations.